Adopted December 13, 1997 by the Managed Health Care Improvement Task Force

NEW QUALITY INFORMATION DEVELOPMENT FINDINGS AND RECOMMENDATIONS

I. FINDINGS

The purpose of this paper is to identify ways in which the state can improve the quality- related information collected and available for consumers, providers, health plans, employers, policy makers and others. A well-informed and well-educated public with appropriate choice and access to quality health care is key to improved health. The current array of health care quality information is insufficient. Limitations include the following:

- Comparative data are scarce, and paper charts are not amenable to large-scale quality of care evaluations.
- Risk adjustment is needed to level the playing field for analyzing clinical outcomes, and to reduce adverse selection. (See the Task Force paper on Minimizing Risk Avoidance Strategies.)
- Consumers, patients and purchasers do not have enough of the right sorts of information necessary to make informed decisions about health care options related to treatments, providers, plans[1] or carriers.

Providers are hampered in their ability to deliver excellent care by limited data to support evidence-based medicine. State efforts at data collection have been limited because each data element is included in statute, collected elements are confined to the hospital discharge abstract and reporting cycles are long. These limitations impede the timeliness and usefulness of resulting information. To improve these shortcomings we recommend the following actions. Wherever possible, efforts should be coordinated among all levels of government and with the private sector.

There will be significant initial investment cost attached to expanding and enhancing the information about the quality of health care in California. The investment is necessary if we are to improve the quality of health care, managed or unmanaged. Moreover, by helping providers to learn which therapies work and which do not, improved data can contribute to reduced cost in the long run by eliminating ineffective or harmful therapies. Data should be collected and reported only if it can help providers improve the quality of care, reduce the cost of care (without reducing the quality of outcomes) and/or help consumers or purchasers choose among health plans and providers, or among treatment options.

II. RECOMMENDATIONS

A. Transition from a Statutory to a Regulatory Approach to Data Collection

1. (a) The Task Force recommends that the state health data programs be given the authority to request specific new data elements from health plans and providers to support new quality measurement initiatives. Broad data guidelines should be set by the Legislature, but the state programs should be given the flexibility to innovate. The state entity(ies) for regulation of managed care[2] should approve data requests (e.g., data elements) and make specific findings regarding cost and benefits.

   (b) The state entity(ies) for regulation of managed care should be authorized to convene an advisory body composed of stakeholders[3], to evaluate specific data requests. Such requests should balance the cost and value of information to be provided. Redundant information requests should be reconciled.

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[1] "Health plans," refer to any health insurance arrangements, also known as health benefits financial intermediaries.

[2] The state entity(ies) for regulation of managed care refer to DOC, DOI, or their successor.

[3] The intention of the Task Force is that stakeholders include, but are not limited to, consumers groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

The advisory body should encourage data requesters to employ valid and reliable statistical sampling techniques when feasible. The state entity(ies) for regulation of managed care should coordinate data requests from all requesters to avoid duplication.

B. Advance Implementation of Electronic Medical Records

Electronically storable and retrievable encounter and clinical data are needed so that medical groups and providers can monitor and improve their own practices, so health plans can monitor groups, so purchasers and accreditation organizations and the regulatory authority can monitor health plans and so purchasers and health plans can implement adequate risk adjustment mechanisms across health plans and providers.

2. (a) The Task Force recommends that the state entity(ies) for regulation of managed care be aware of, participate in, and actively help where possible, ongoing private and public sector efforts, such as those that have been initiated collectively by Pacific Business Group on Health (PBGH), National Independent Practice Association Coalition (NIPAC), American Medical Group Association (AMGA), California Medical Association (CMA), California Healthcare Association (CHA) and California Association of Health Plans (CAHP), to develop standardized eligibility, enrollment and encounter data.

   (b) The state entity(ies) for regulation of managed care should strongly encourage, by providing leadership and coordination, that components of electronic medical records (starting with encounter data), based on systems that permit easy sharing and exchange of data be phased in with a target date of 2002-2004 depending on the size and resources of the medical groups, health plans, clinics and hospitals.

   (c) This strategy should include strict provisions for maintaining patient privacy and confidentiality including fire walls between individual patient data and employers. The state entity(ies) for regulation of managed care should impose severe penalties for individuals or organizations if they abuse the release of individual patient data. (See also the Task Force paper on Physician-Patient Relationship)

   (d) The Task Force recommends to the President and the U.S. Congress that the federal government should assume responsibility for establishing technical standards for electronic communication of health care information (such as uniform identifiers for patients and providers and uniform language and data definitions), standards for confidentiality and standards for information security. Federal initiatives in these areas will help ensure compatibility and comparability of information across states. This will assist the study of health outcomes regionally and nationally.

C. Collect Health Information at the Treatment Level

3. (a) The Task Force recommends that health care information be collected and disseminated not only at the health plan level, but at the treatment level including hospital, clinic, medical group/IPA, ambulatory center, home health and nursing home levels. Information should emphasize and compare outcomes whenever possible and make specific findings as to the value and the cost of the collection and dissemination of the data. (See the Task Force paper on Consumer Information, Communication and Involvement.) Information should be reported by local geographic area where people are likely to seek and receive health care services. The state entity(ies) for regulation of managed care should either disseminate the above health plan and treatment level information to the public or assure that private dissemination of this information occurs and is widely available and easily accessible.

(b) The Task Force recommends that the state entity(ies) for regulation of managed care be aware of, participate in and actively help where possible, ongoing private sector efforts to develop and distribute these data.

D. Ensure Basic Safety Standards for Patient Care

There are some instances when quality information should be monitored to ensure the basic safety of the public. Collecting, monitoring, auditing and most of all improving clinical care based on these data serves a greater public good and should be required by public regulation and required by private accreditation.

4. The Task Force recommends that the state entity(ies) for regulation of managed care in coordination with OSHPD and DHS, create a blue ribbon panel (to include stakeholders and private accrediting organizations such as JCAHO and NCQA) to study and report by June 1, 1999 on ways to help improve patient safety in health care by reducing errors, adverse events and adverse outcomes. Specific areas to study should include variations in number and rates of adverse drug events, hospital and surgical infection rates, patient falls and pressure ulcers, and variations in risk-adjusted mortality and morbidity rates for major surgeries and treatments.